STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING _____ B. WING _____	C 10/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LN CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00211161.

This visit was in conjunction with the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00209267.

Complaint IN00211161 - Substantiated - No deficiencies related to the allegations are cited.

Complaint IN00209267 - Substantiated - No deficiencies related to the allegations are cited.

Survey dates: September 27, 28, 29, 30, October 3 and 4, 2016.

Facility number: 000166
Provider number: 155265
AIM number: 100267080

Census bed type:
SNF: 8
SNF/NF: 85
Total: 93

Census payor type:
Medicare: 12
Medicaid: 64
Other: 17
Total: 93

Sample: 7

Kindred Transitional Care and Rehab - Wedgewood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING _____ B. WING _____	C 10/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LN CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 16.2-3.1 in regard to the Investigation of Complaint IN00211161. Quality review completed by 34233 on October 6, 2016. Survey dates: July 12 and 13, 2016. Facility number: 000059 Provider number: 155697 AIM number: 100266560 Census bed type: SNF: 06 SNF/NF: 63 Total: 69 Census payor type: Medicare: 11 Medicaid: 42 Other: 16	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING _____ B. WING _____	C 10/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LN CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 Total: 69 Sample: 3	F 000		